DEPARTMENT OF HEALTH
AND HOSPITALS

Health Standards Section
Change of Ownership
HOSPICE

Federal and State regulations require that copies of all documents relating to the change of ownership be submitted along with a description of the change of ownership (lease, purchase of assets, etc.), the effective date and the name and address of the old owner and the new owner. The change of ownership **must be filed within five working days of the effective date** per state licensing standards.

The hospice license is not transferable; therefore, another licensing application, and licensing fee must be submitted. The fee of $600.00 plus $5.00 per unit (room or station - inpatient only) must be in the form of a company check, certified check, or money order payable to the Department of Health and Hospitals.

For participation in the Medicare program, all providers/suppliers must complete the CMS 855 form, Medicare Federal Health Care Provider/Supplier Application for Health Care Providers or Suppliers. The application must be obtained from the provider/supplier's chosen fiscal intermediary or carrier. The Centers for Medicare and Medicaid Services (CMS) website located @ http://www.cms.hhs.gov/MedicareProviderSupEnroll/, contains a list of FIs and carriers by state and specialty. The FI/Carrier will answer any inquiries concerning completion of the enrollment application.

The forms applicable to the change of ownership are enclosed. Please note that if more than one copy of the same form is included, we must have these completed with original signatures.

FORMS INCLUDED:

HSS-HP-1	HP License Application	(1)
HSS-1513L		(1)
CMS 417		(1)
CMS 1561		(2)
Office for Civil Rights Forms Memo		(1)

In addition to the forms listed above you must include a bill of sale and articles of incorporation (certified copy). If you have any questions, please contact the program manager at (225) 342-6446.

At the direction of the Dallas Regional office of the CMS, the Louisiana State Agency will no longer be making recommendations or inquiring about provider-based designation status. Prospective providers and/or suppliers that have questions as to whether they meet the criteria for provider-based designation are instructed to contact: Patty Rawlings with the CMS at (214) 767-4423.

Health Standards Section
P.O. Box 3767 • Baton Rouge, Louisiana 70821-3767
Phone #: 225/342-0138 • Fax #: 225/342-0157 • http://new.dhh.louisiana.gov/

DEPARTMENT OF HEALTH
AND HOSPITALS

Health Standards Section
License Application
HOSPICE

☐ *INITIAL* ☐ *RENEWAL* ☐ *OTHER* (Specify) _____

LICENSE NUMBER _____ *EXPIRATION DATE* _____

TOTAL FEE AMOUNT INCLUDED _____ *CHECK / MONEY ORDER #* _____

☐ check if any change has occurred since last application **STATE ID #HP**__ __ __ __ __ __ __

I. *FACILITY (DBA) NAME* _____

GEOGRAPHICAL ADDRESS _____

CITY / STATE / ZIP _____ *PARISH* _____

TELEPHONE NUMBER (____) _____ *FAX NUMBER* (___) _____ *EMAIL ADDRESS* _____

II. MAILING. ADDRESS *(IF DIFFERENT FROM ABOVE)* _____

CITY / STATE / ZIP _____ *PARISH* _____

III. *ADMINISTRATOR* _____ *DIRECTOR OF NURSING* _____

IV. TYPE OF HOSPICE:

_____ *HOSPITAL* _____ *SKILLED NURSING HOME* _____ *INTERMEDIATE CARE FACILITY* _____ *HOME HEALTH*

FREE STANDING: ☐ *Yes* ☐ *No* *MEDICARE CERTIFIED* ☐ *Yes* ☐ *No*

V. TYPE OF OWNERSHIP:

NON- PROFIT	FOR – PROFIT	GOVERNMENT
☐ *INDIVIDUAL/SOLE PROPRIETOR*	☐ *INDIVIDUAL/SOLE PROPRIETOR*	☐ *FEDERAL*
☐ *CORPORATION*	☐ *CORPORATION*	☐ *STATE*
☐ *PARTNERSHIP*	☐ *PARTNERSHIP*	☐ *PARISH*
(Specify): _____	☐ *GROUP PRACTICE*	☐ *CITY/PARISH*
☐ *RELIGIOUS AFFILIATION*	☐ *OTHER (Specify):*	☐ *CITY*
☐ *UNINCORPORATED ASSOCIATION*	_____	☐ *COMBINATION GOV-N-PROFIT*
☐ *OTHER (Specify):*		☐ *HOSPITAL DISTRICT*
_____		☐ *OTHER* _____

VI. *ENTITY / CORPORATION NAME* _____

MAILING ADDRESS (IF DIFFERENT) _____

CITY / STATE / ZIP _____

TELEPHONE NUMBER (____) _____ *FAX NUMBER* (____) _____ *EIN#* _____

VII. *List name, address, and telephone numbers for persons or group of persons having direct or indirect ownership or a controlling interest (≥ 5%) of the corporate stock or partnership interest or any person or business entity which has a direct business interest, including, but not limited to, a wholly owned subsidiary, the details of any conversion rights which may exist for the benefit of any party and whether such stock, partnership interest, or ownership being held by the disclosed person or business entity is, in fact, owned by another person or business entity (ATTACH ADDITIONAL SHEETS IF ADDITIONAL SPACE IS NEEDED).*

OWNER NAME	ADDRESS	TELEPHONE #

HSS-HP-01 (revised 12/08; 12/11; 01/12; 02/12; 06/12)

HOSPICE LICENSE APPLICATION

VIII. If the disclosing entity is a corporation, list name, address and telephone number of the President.

NAME	ADDRESS	TELEPHONE NUMBER

IX. Are any owners of the disclosing entity also owners of other licensed health care facilities? ☐ *Yes* ☐ *No*
(Proprietorship, Partnership or Board Member) If yes, list names, addresses of individuals and other provider numbers.

NAME	ADDRESS	PROVIDER NUMBER

X. Has there been a change of ownership or control within the last year? ☐ *Yes* ☐ *No*
If yes, give date: _____

XI. ACCREDITATION: (check all that apply):

☐ *JCAHO* ☐ *CHAP* ☐ *Other (specify* _____ *)* *Status of Accreditation:* ☐ *Accredited* ☐ *Deemed*

XII. PROGRAM OPERATIONAL INFORMATION

NUMBER OF CURRENT ACTIVE PATIENTS _____ *TOTAL NUMBER OF LICENSED BEDS (If applicable)* _____

NUMBER OF SATELLITE, BRANCH OR OFFSITE OFFICES (If applicable) _____

NUMBER OF UNITS, ROOMS, STATIONS (If applicable) _____

LIST THE GEOGRAPHICAL ADDRESS AND TELEPHONE NUMBER OF ALL SATELLITE, BRANCH OR OFFSITE OFFICES BELOW:

_____ _____

_____ _____

_____ _____

☐ *Check if any change has occurred since last application*

XIII. SERVICES PROVIDED
Place a "1" in the blank for services provided by Direct Staff. Place a "2" in the blank if services are provided under arrangement. NOTE: CORE services must be provided directly by the Hospice and not under arrangement.

CORE SERVICES:
_____ *Physician* _____ *Nursing* _____ *Social* _____ *Counseling*

OTHER SERVICES:
_____ *Physical Therapy* _____ *Occupational Therapy* _____ *Speech- Language Therapy* _____ *Home Health Aide*

_____ *Homemaker* _____ *Medical Supplies* _____ *Short Term Inpatient Care* _____ *Acute* _____ *Respite*

_____ *Other (Specify):* _____

ATTESTATION: I understand that if the agency license is granted, it is granted for one year and shall become void upon change of ownership. It is my responsibility to notify the Department of Health and Hospitals, Health Standards Section in writing of any changes in the information provided in this application. I certify that the information herein is true, correct, and supportable by documentation to the best of my knowledge. Documentation of the information above is available upon request by the Department of Health and Hospitals.

_____
AUTHORIZED REPRESENTATIVE NAME (TYPED OR PRINTED)

_____ _____
AUTHORIZED REPRESENTATIVE SIGNATURE *DATE*

Louisiana Department of Health and Hospitals
Health Standards Section

Disclosure of Ownership & Controlling Interest Statement

I. Identifying Information

Legal Entity/Corp. Name:	
D/B/A Name:	
Employer ID Number (EIN):	
Street Address:	
City:	State :
Parish/County:	Zip Code:
Phone Number:	Email :

II. (a) List names, addresses and phone numbers for persons or group of persons, or the Employer Identification Number (EIN) for organizations having direct or indirect ownership or a controlling interest (≥ 5%) of the corporate stock or partnership interest or any person or business entity which has a direct business interest, including, but not limited to, a wholly owned subsidiary, the details of any conversion rights which may exist for the benefit of any party and whether such stock, partnership interest, or ownership being held by the disclosed person or business entity is, in fact, owned by another person or business entity.

Name	Address	EIN #

II. (b) Type of Entity:

For-Profit Entity	Non-Profit Entity	Government Entity
☐ Individual/Sole Proprietorship	☐ Individual/Sole Proprietorship	☐ Federal
☐ Corporation	☐ Corporation	☐ State
☐ Partnership	☐ Partnership	☐ Parish
☐ Group Practice	☐ Religious Affiliate	☐ City/Parish
☐ Religious Affiliate	☐ Unincorporated Association	☐ City
☐ Unincorporated Association	☐ Limited Liability Corporation	☐ Hospital District
☐ Limited Liability Corporation	☐ Other :	☐ Combination Gov/Non-Profit
☐ Other :		☐ Human Services District
		☐ Other :

II. (c) If the disclosing entity is a corporation, list names, addresses, and phone numbers of the Directors and attach.

II. (d) Are any owners of the disclosing entity also owners of other licensed health care facilities? ☐ **Yes** ☐ **No**
(proprietorship, partnership, or Board Members). If yes, list names, addresses, and phone numbers of individuals and facility provider numbers.

Name	Address	Provider Number

III. Has there been a change in ownership or control within the last year?

☐ **NO** change of ownership.	☐ **YES**, ownership has changed. **Date** of Ownership Change:

WHOEVER KNOWINGLY AND WILLFULLY MAKES OR CAUSES TO BE MADE A FALSE STATEMENT OR REPRESENTATION OF THIS STATEMENT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS, IN ADDITION, KNOWINGLY AND WILLFULLY FAILING TO FULLY AND ACCURATELY DISCLOSE THE INFORMATION REQUESTED MAY RESULT IN DENIAL OF A REQUEST TO PARTICIPATE OR WHERE THE ENTITY ALREADY PARTICIPATES, A TERMINATION OF ITS AGREEMENT OR CONTRACT WITH THE LOUISIANA STATE AGENCY

Print Name and Title of Authorized Representative:	
Signature:	**Date:**
Notes/Remarks:	

Form HSS-1513L (7/11; 01/12; 02/12; 3/12, 3/13)

INSTRUCTIONS FOR COMPLETING HOSPICE REQUEST FOR CERTIFICATION IN THE MEDICARE PROGRAM

STATEMENT CONCERNING INFORMATION COLLECTION REQUIREMENTS AND USES

This form is required to obtain or retain Medicare benefits. It serves two purposes. First, it provides basic information about the Hospice which is necessary for the State to properly schedule a survey. Second, it provides a data-base necessary for responding to questions frequently asked by Congress, Federal agencies, and interested members of the public.

Submission of this form will initiate the process of obtaining a decision as to whether the Conditions are met.

Answer all questions as of the current date. Return the original and first two copies to the State Agency; retain the last copy for your files. If a return envelope is not provided, the name and address of the State Agency may be obtained from the nearest Social Security Office.

Detailed instructions are given for questions other than those considered self-explanatory.

Item I

- Request to establish eligibility in - current Hospice Benefits are available only through the Medicare program.
- Medicare provider number - insert the facility's six digit Medicare Provider Number. Leave blank on initial requests for certification.
- State/County and State/Region Codes – Leave blank. The Centers for Medicare & Medicaid Services Regional Office will complete.
- Related provider number – If Hospice is affiliated with any other type Medicare provider, insert the related facility's six digit Medicare Provider Number.

Item IV – If a service is provided directly by the facility place a "1" the appropriate block. If a service is provided through an outside source (i.e., by contract/arrangement), place a "2" in the appropriate block.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0313

HOSPICE REQUEST FOR CERTIFICATION IN THE MEDICARE PROGRAM

(Read Instructions and Information Collection Statement On Cover Sheet of Form Prior to Completion)

I. Identifying Information

Name of Hospice

Street Address

Request to Establish Eligibility In
1. ____ Medicare
PH1

City, County and State

Zip Code

Medicare/Provider Number
PH2

State/County
PH3

State/Region
PH4

Telephone Number *(include area code)*
PH5

Related Provider Number
PH6

II. Type of Hospice *(Check One)*
PH7

1. ☐ Hospital
2. ☐ Skilled Nursing Facility
3. ☐ Intermediate Care Facility
4. ☐ Home Health Agency
5. ☐ Freestanding Hospice

For Hospitals Only *(Check One)*
A. ☐ JCAH Accredited
B. ☐ AOA Accredited
C. ☐ Both JCAH and AOA Accredited
D. ☐ Non-Accredited

Fiscal Year Ending Date

III. Type of Control *(Check One)*
PH8

Non-Profit
1. ☐ Church
2. ☐ Private
3. ☐ Other

Proprietary
4. ☐ Individual
5. ☐ Partnership
6. ☐ Corporation
7. ☐ Other

Government
8. ☐ State
9. ☐ County
10. ☐ City
11. ☐ City-County

12. ☐ Combination Government and Nonprofit
13. ☐ Other

IV. Services Provided:
By staff, place a "1" in the block(s)
If under arrangement, place a "2" in the block(s)
PH9

Core:
1. ☐ Physician Services
2. ☐ Nursing Services
3. ☐ Medical Social Services
4. ☐ Counseling Services

5. ☐ Physical Therapy
6. ☐ Occupational Therapy
7. ☐ Speech-Language Pathology
8. ☐ Home Health Aide
9. ☐ Homemaker
10. ☐ Medical Supplies
11. ☐ Short Term Inpatient Care — PH10 A. _____Acute B. _____Respite
12. ☐ Other(Specify)

Name and Address of Contractee

Medicare Provider/Supplier Number

V. Number of Employees/ Volunteers Full-time Equivalent (Top section of professional category reflects total number of FTE (i.e., PH 11 through PH 18))

Physicians PH11		Registered Professional Nurses PH12		Licensed Practical Nurses/ Licensed Vocational Nurses		Medical Social Workers PH14		Total Number PH19	
Employees A.	Volunteers B.	Employees A.	Volunteers B.	Employees A.	Volunteers B.	Employees A.	Volunteers B.	Employees A.	Volunteers B.
Homemakers PH15		**Home Health Aide PH16**		**Counselors PH17**		**Others PH18**			
Employees A.	Volunteers B.	Employees A.	Volunteers B.	Employees A.	Volunteers B.	Employees A.	Volunteers B.		

Whoever knowingly or willfully makes or causes to be made a false statement or representation on this form may be prosecuted under applicable Federal or State laws. In addition, knowingly and willfully failing to fully and accurately disclose the information requested may result in denial of a request to participate, or where the entity already participates, a termination of its agreement or contract with the State agency or the Secretary as appropriate.

Name of Authorized Representative and Title (Typed)	Signature	Date PH20

Form CMS-417 (04/84)

PART 2 REGIONAL OFFICE

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0313

HOSPICE REQUEST FOR CERTIFICATION IN THE MEDICARE PROGRAM

(Read Instructions and Information Collection Statement On Cover Sheet of Form Prior to Completion)

I. Identifying Information

Name of Hospice

Street Address

Request to Establish Eligibility In
1. ____ Medicare
PH1

City, County and State

Zip Code

Medicare/Provider Number
PH2

State/County
PH3

State/Region
PH4

Telephone Number *(include area code)*
PH5

Related Provider Number
PH6

II. Type of Hospice *(Check One)*
PH7

1. ☐ Hospital
2. ☐ Skilled Nursing Facility
3. ☐ Intermediate Care Facility
4. ☐ Home Health Agency
5. ☐ Freestanding Hospice

For Hospitals Only *(Check One)*
A. ☐ JCAH Accredited
B. ☐ AOA Accredited
C. ☐ Both JCAH and AOA Accredited
D. ☐ Non-Accredited

Fiscal Year Ending Date

III. Type of Control *(Check One)*
PH8

Non-Profit
1. ☐ Church
2. ☐ Private
3. ☐ Other

Proprietary
4. ☐ Individual
5. ☐ Partnership
6. ☐ Corporation
7. ☐ Other

Government
8. ☐ State
9. ☐ County
10. ☐ City
11. ☐ City-County

12. ☐ Combination Government and Nonprofit
13. ☐ Other

IV. Services Provided: By staff, place a "1" in the block(s) If under arrangement, place a "2" in the block(s)
PH9

Core:
1. ☐ Physician Services
2. ☐ Nursing Services
3. ☐ Medical Social Services
4. ☐ Counseling Services

5. ☐ Physical Therapy
6. ☐ Occupational Therapy
7. ☐ Speech-Language Pathology
8. ☐ Home Health Aide
9. ☐ Homemaker
10. ☐ Medical Supplies
11. ☐ Short Term Inpatient Care — PH10
    A. _____Acute
    B. _____Respite
12. ☐ Other(Specify)

Name and Address of Contractee

Medicare Provider/Supplier Number

V. Number of Employees/ Volunteers Full-time Equivalent (Top section of professional category reflects total number of FTE (i.e., PH 11 through PH 18))

Physicians PH11		Registered Professional Nurses PH12		Licensed Practical Nurses/ Licensed Vocational Nurses		Medical Social Workers PH14		Total Number	
Employees A.	Volunteers B.	Employees A.	Volunteers B.	Employees A.	Volunteers B.	Employees A.	Volunteers B.	Employees PH19 A.	Volunteers B.
Homemakers PH15		**Home Health Aide PH16**		**Counselors PH17**		**Others PH18**			
Employees A.	Volunteers B.	Employees A.	Volunteers B.	Employees A.	Volunteers B.	Employees A.	Volunteers B.		

Whoever knowingly or willfully makes or causes to be made a false statement or representation on this form may be prosecuted under applicable Federal or State laws. In addition, knowingly and willfully failing to fully and accurately disclose the information requested may result in denial of a request to participate, or where the entity already participates, a termination of its agreement or contract with the State agency or the Secretary as appropriate.

Name of Authorized Representative and Title (Typed)	Signature	Date PH20

Form CMS-417 (04/84)

PART 3 STATE AGENCY

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0313

HOSPICE REQUEST FOR CERTIFICATION IN THE MEDICARE PROGRAM

(Read Instructions and Information Collection Statement On Cover Sheet of Form Prior to Completion)

I. Identifying Information

Name of Hospice

Street Address

Request to Establish Eligibility In
1. ____ Medicare
PH1

City, County and State

Zip Code

Medicare/Provider Number
PH2

State/County
PH3

State/Region
PH4

Telephone Number *(include area code)*
PH5

Related Provider Number
PH6

II. Type of Hospice *(Check One)*
PH7

1. ☐ Hospital
2. ☐ Skilled Nursing Facility
3. ☐ Intermediate Care Facility
4. ☐ Home Health Agency
5. ☐ Freestanding Hospice

For Hospitals Only *(Check One)*
A. ☐ JCAH Accredited
B. ☐ AOA Accredited
C. ☐ Both JCAH and AOA Accredited
D. ☐ Non-Accredited

Fiscal Year Ending Date

III. Type of Control *(Check One)*
PH8

Non-Profit
1. ☐ Church
2. ☐ Private
3. ☐ Other

Proprietary
4. ☐ Individual
5. ☐ Partnership
6. ☐ Corporation
7. ☐ Other

Government
8. ☐ State
9. ☐ County
10. ☐ City
11. ☐ City-County

12. ☐ Combination Government and Nonprofit
13. ☐ Other

IV. Services Provided:
By staff, place a "1" in the block(s)
If under arrangement, place a "2" in the block(s)
PH9

Core:
1. ☐ Physician Services
2. ☐ Nursing Services
3. ☐ Medical Social Services
4. ☐ Counseling Services

5. ☐ Physical Therapy
6. ☐ Occupational Therapy
7. ☐ Speech-Language Pathology
8. ☐ Home Health Aide
9. ☐ Homemaker
10. ☐ Medical Supplies
11. ☐ Short Term Inpatient Care — PH10
A. _____ Acute
B. _____ Respite
12. ☐ Other(Specify)

Name and Address of Contractee

Medicare Provider/Supplier Number

V. Number of Employees/ Volunteers Full-time Equivalent (Top section of professional category reflects total number of FTE (i.e., PH 11 through PH 18))

Physicians PH11		Registered Professional Nurses PH12		Licensed Practical Nurses/ Licensed Vocational Nurses		Medical Social Workers PH14		Total Number PH19	
Employees A.	Volunteers B.	Employees A.	Volunteers B.	Employees A.	Volunteers B.	Employees A.	Volunteers B.	Employees A.	Volunteers B.
Homemakers PH15		**Home Health Aide PH16**		**Counselors PH17**		**Others PH18**			
Employees A.	Volunteers B.	Employees A.	Volunteers B.	Employees A.	Volunteers B.	Employees A.	Volunteers B.		

Whoever knowingly or willfully makes or causes to be made a false statement or representation on this form may be prosecuted under applicable Federal or State laws. In addition, knowingly and willfully failing to fully and accurately disclose the information requested may result in denial of a request to participate, or where the entity already participates, a termination of its agreement or contract with the State agency or the Secretary as appropriate.

Name of Authorized Representative and Title (Typed)	Signature	Date PH20

Form CMS-417 (04/84)

PART 4

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0313

HOSPICE REQUEST FOR CERTIFICATION IN THE MEDICARE PROGRAM

(Read Instructions and Information Collection Statement On Cover Sheet of Form Prior to Completion)

I. Identifying Information

Name of Hospice

Street Address

Request to Establish Eligibility In
1. ____ Medicare
PH1

City, County and State

Zip Code

Medicare/Provider Number
PH2

State/County
PH3

State/Region
PH4

Telephone Number *(include area code)*
PH5

Related Provider Number
PH6

II. Type of Hospice *(Check One)*
PH7

1. ☐ Hospital
2. ☐ Skilled Nursing Facility
3. ☐ Intermediate Care Facility
4. ☐ Home Health Agency
5. ☐ Freestanding Hospice

For Hospitals Only *(Check One)*
A. ☐ JCAH Accredited
B. ☐ AOA Accredited
C. ☐ Both JCAH and AOA Accredited
D. ☐ Non-Accredited

Fiscal Year Ending Date

III. Type of Control *(Check One)*
PH8

Non-Profit
1. ☐ Church
2. ☐ Private
3. ☐ Other

Proprietary
4. ☐ Individual
5. ☐ Partnership
6. ☐ Corporation
7. ☐ Other

Government
8. ☐ State
9. ☐ County
10. ☐ City
11. ☐ City-County

12. ☐ Combination Government and Nonprofit
13. ☐ Other

IV. Services Provided:
By staff, place a "1" in the block(s)
If under arrangement, place a "2" in the block(s)
PH9

Core:
1. ☐ Physician Services
2. ☐ Nursing Services
3. ☐ Medical Social Services
4. ☐ Counseling Services

5. ☐ Physical Therapy
6. ☐ Occupational Therapy
7. ☐ Speech-Language Pathology
8. ☐ Home Health Aide
9. ☐ Homemaker
10. ☐ Medical Supplies
11. ☐ Short Term Inpatient Care — PH10
A. _____Acute
B. _____Respite
12. ☐ Other(Specify)

Name and Address of Contractee

Medicare Provider/Supplier Number

V. Number of Employees/ Volunteers Full-time Equivalent (Top section of professional category reflects total number of FTE (i.e., PH 11 through PH 18))

Physicians PH11		Registered Professional Nurses PH12		Licensed Practical Nurses/ Licensed Vocational Nurses		Medical Social Workers PH14		Total Number
Employees	Volunteers	Employees	Volunteers	Employees	Volunteers	Employees	Volunteers	PH19
A.	B.	A.	B.	A.	B.	A.	B.	

Homemakers PH15		Home Health Aide PH16		Counselors PH17		Others PH18		Employees	Volunteers
Employees	Volunteers	Employees	Volunteers	Employees	Volunteers	Employees	Volunteers		
A.	B.	A.	B.	A.	B.	A.	B.	A.	B.

Whoever knowingly or willfully makes or causes to be made a false statement or representation on this form may be prosecuted under applicable Federal or State laws. In addition, knowingly and willfully failing to fully and accurately disclose the information requested may result in denial of a request to participate, or where the entity already participates, a termination of its agreement or contract with the State agency or the Secretary as appropriate.

Name of Authorized Representative and Title (Typed)	Signature	Date PH20

Form CMS-417 (04/84)

PART 5 PROVIDER

FORM APPROVED
OMB No. 0938-0832

HEALTH INSURANCE BENEFIT AGREEMENT

(Agreement with Provider Pursuant to Section 1866 of the Social Security Act, as Amended and Title 42 Code of Federal Regulations (CFR) Chapter IV, Part 489)

AGREEMENT

between

THE SECRETARY OF HEALTH AND HUMAN SERVICES

and

_____

doing business as (D/B/A) _____

In order to receive payment under title XVIII of the Social Security Act,_____

D/B/A _____ as the provider of services, agrees to conform to the provisions of section of 1866 of the Social Security Act and applicable provisions in 42 CFR.

This agreement, upon submission by the provider of services of acceptable assurance of compliance with title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973 as amended, and upon acceptance by the Secretary of Health and Human Services, shall be binding on the provider of services and the Secretary.

In the event of a transfer of ownership, this agreement is automatically assigned to the new owner subject to the conditions specified in this agreement and 42 CFR 489, to include existing plans of correction and the duration of this agreement, if the agreement is time limited.

ATTENTION: Read the following provision of Federal law carefully before signing.

Whoever, in any matter within the jurisdiction of any department or agency of the United States knowingly and willfully falsifies, conceals or covers up by any trick, scheme or device a material fact, or make any false, fictitious or fraudulent statement or representation, or makes or uses any false writing or document knowing the same to contain any false, fictitious or fraudulent statement or entry, shall be fined not more than $10,000 or imprisoned not more than 5 years or both (18 U.S.C. section 1001).

Name _____ Title _____

Date _____

ACCEPTED FOR THE PROVIDER OF SERVICES BY:

NAME *(signature)*

TITLE	DATE

ACCEPTED BY THE SECRETARY OF HEALTH AND HUMAN SERVICES BY:

NAME *(signature)*

TITLE	DATE

ACCEPTED FOR THE SUCCESSOR PROVIDER OF SERVICES BY:

NAME *(signature)*

TITLE	DATE

HEALTH INSURANCE BENEFIT AGREEMENT

(Agreement with Provider Pursuant to Section 1866 of the Social Security Act, as Amended and Title 42 Code of Federal Regulations (CFR) Chapter IV, Part 489)

AGREEMENT

between

THE SECRETARY OF HEALTH AND HUMAN SERVICES

and

_____

doing business as (D/B/A) _____

In order to receive payment under title XVIII of the Social Security Act,_____

D/B/A _____ as the provider of services, agrees to conform to the provisions of section of 1866 of the Social Security Act and applicable provisions in 42 CFR.

This agreement, upon submission by the provider of services of acceptable assurance of compliance with title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973 as amended, and upon acceptance by the Secretary of Health and Human Services, shall be binding on the provider of services and the Secretary.

In the event of a transfer of ownership, this agreement is automatically assigned to the new owner subject to the conditions specified in this agreement and 42 CFR 489, to include existing plans of correction and the duration of this agreement, if the agreement is time limited.

ATTENTION: Read the following provision of Federal law carefully before signing.

Whoever, in any matter within the jurisdiction of any department or agency of the United States knowingly and willfully falsifies, conceals or covers up by any trick, scheme or device a material fact, or make any false, fictitious or fraudulent statement or representation, or makes or uses any false writing or document knowing the same to contain any false, fictitious or fraudulent statement or entry, shall be fined not more than $10,000 or imprisoned not more than 5 years or both (18 U.S.C. section 1001).

Name _____ Title _____

Date _____

ACCEPTED FOR THE PROVIDER OF SERVICES BY:

NAME *(signature)*

TITLE	DATE

ACCEPTED BY THE SECRETARY OF HEALTH AND HUMAN SERVICES BY:

NAME *(signature)*

TITLE	DATE

ACCEPTED FOR THE SUCCESSOR PROVIDER OF SERVICES BY:

NAME *(signature)*

TITLE	DATE

DEPARTMENT OF HEALTH
AND HOSPITALS

HEALTH STANDARDS SECTION

Office of Civil Rights Forms

Instructions

Required Office of Civil Rights (OCR) forms must be completed and submitted with each Change of Ownership (CHOW) and/or Initial Provider Certification Packet. These provider completed forms are used by the OCR to process clearance for the facilities undergoing CHOWS and Initial Certification. The role of this agency (Health Standards Section of the Louisiana Department of Health and Hospitals) is limited to collecting and forwarding the civil rights data to Center for Medicare and Medicaid Services (CMS), who will then forward to the OCR. The OCR Civil Rights Information Request For Medicare Certification Form, and the Form HHS-690 Assurance of Compliance are included as a part of the state agency packet. All other information that is required by OCR and that must be submitted is described on the OCR website at:

http://www.hhs.gov/ocr/civilrights/resources/providers/medicare_providers/index.html

Carefully read the information on this website regarding Civil Rights Certification for Medicare Provider Applicants (that is located on the above website) for a complete listing of the documents required for submission by OCR.

Any questions concerning the forms must be directed to the regional HHS Office for Civil Rights **(Phone #214-767-4056).**

Please be aware that completed CHOW or Initial Certification packets will not be forwarded to the CMS for processing until all completed OCR forms have been returned to this agency.

Health Standards Section
P.O. Box 3767 • Baton Rouge, Louisiana 70821-3767
Phone #: 225/342-0138 • Fax #: 225/342-5073 • http://new.dhh.louisiana.gov/

Form Approved
OMB No. 0990-0243
Exp. Date 03/31/2014

DEPARTMENT OF HEALTH & HUMAN SERVICES
Office for Civil Rights (OCR)
Civil Rights Information Request
For Medicare Certification

Instructions: Healthcare providers applying for participation in the Medicare Part A program must receive a civil rights clearance from OCR. Complete all fields and return this form, with the required policies and procedures, to your State Health Department, along with your other Medicare application materials.

I. Healthcare Provider Information

CMS Medicare Provider Number:

Name of Facility:

Address: _____
Street Number and Name

_____ _____ _____ -
City or Town *State or Province* *Zip Code*

Administrator's Name: _____ Contact Person: _____

Telephone: ( ) - _____ TDD: ( ) - _____

FAX: ( ) - _____ E-mail: _____

Type of Facility: _____ Number of employees: _____

Corporate Affiliation: _____ Reason for Application: Circle One
Initial Medicare Certification or Change of Ownership

II. Documents Required for Submission

Additional guidance is available at: (http://www.hhs.gov/ocr/civilrights/clearance/index.html)

1.	Assurance of Compliance Form, HHS 690 completed, signed and dated.
2.	Nondiscrimination Policy that provides for admission and services without regard to race, color, national origin, disability, or age, as required by Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975 (see sample policy). Learn more about regulatory requirements
3.	Description of methods used to disseminate your nondiscrimination policies/notices: a) Describe where you post your Nondiscrimination Policy; and b) Include brochures, websites, pamphlets, postings, or ads with general information about your services.
4.	Facility admissions policy that describes eligibility requirements for your services.
5.	A description/explanation of any policies or practices restricting or limiting your facility's admissions or services on the basis of age. In certain narrowly defined circumstances, age restrictions are permitted. Learn more about regulatory requirements
6	For healthcare providers with 15 or more employees: copy of your procedures used for handling disability discrimination grievances along with the name/title and telephone number of the Section 504 coordinator (see sample policy). Learn more about regulatory requirements

DEPARTMENT OF HEALTH & HUMAN SERVICES
Office for Civil Rights (OCR)
Civil Rights Information Request
For Medicare Certification

7.	Procedures to effectively communicate with persons who are limited English proficient (LEP), including: a) Process for how you identify individuals who need language assistance; b) Procedures to provide services (interpreters, written translations, bilingual staff, etc.). Include the name(s) and telephone number(s) of your interpreter(s) and/or interpreter service(s); c) Methods to inform LEP persons that language assistance services are available at no cost to the person being served; d) Appropriate restrictions on the use of family and friends as LEP interpreters; and e) A list of all written materials in other languages, if applicable. Examples may include consent and complaint forms, intake forms, written notices of eligibility criteria, nondiscrimination notices, etc (see sample policy). Learn more about regulatory requirements
8.	Procedures used to communicate effectively with individuals who are deaf, hard of hearing, blind, have low vision, or who have other impaired sensory, manual or speaking skills, including: a) Process to identify individuals who need sign language interpreters or other assistive services; b) Procedures to provide interpreters and other auxiliary aids and services. Include the name(s) and telephone number(s) of your interpreter(s) and/or interpreter service(s); c) Procedures used to communicate with deaf or hard of hearing persons over the telephone, including the telephone number of your TTY/TDD or State Relay System; d) A list of available auxiliary aids and services; e) Methods to inform persons that interpreter or other assistive services are available at no cost to the person being served; and f) Appropriate restrictions on the use of family and friends as sign language interpreters (see sample policy). Learn more about regulatory requirements
9.	Notice of Program Accessibility and methods used to disseminate information to patients/clients about the existence and location of services and facilities that are accessible to persons with disabilities (see sample policy). Learn more about regulatory requirements

III Certification

I certify that the information provided to the Office for Civil Rights is true, complete, and correct to the best of my knowledge.

Name and Title of Authorized Official	Signature	Date

ASSURANCE OF COMPLIANCE

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, AND THE AGE DISCRIMINATION ACT OF 1975

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. **Title VI of the Civil Rights Act of 1964** (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.

2. **Section 504 of the Rehabilitation Act of 1973** (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of his or her disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.

3. **Title IX of the Education Amendments of 1972** (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.

4. **The Age Discrimination Act of 1975** (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The person whose signature appears below is authorized to sign this assurance and commit the Applicant to the above provisions.

_____
Date

_____
Signature of Authorized Official

_____
Name and Title of Authorized Official (please print or type)

_____
Name of Healthcare Facility Receiving/Requesting Funding

_____
Street Address

_____
City, State, Zip Code

Please mail form to:

U.S. Department of Health and Human Services
Office for Civil Rights
200 Independence Ave., S.W.
Washington, D.C. 20201

ASSURANCE OF COMPLIANCE

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, AND THE AGE DISCRIMINATION ACT OF 1975

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The person whose signature appears below is authorized to sign this assurance and commit the Applicant to the above provisions.

_____
Date

_____
Signature of Authorized Official

_____
Name and Title of Authorized Official (please print or type)

Please mail form to:

U.S. Department of Health and Human Services
Office for Civil Rights
200 Independence Ave., S.W.
Washington, D.C. 20201

_____
Name of Healthcare Facility Receiving/Requesting Funding

_____
Street Address

_____
City, State, Zip Code

Form HHS-690
3/2011

DEPARTMENT OF HEALTH
AND HOSPITALS

HEALTH STANDARDS SECTION

Fiscal Year End Date

In order to be assured that your Fiscal Year End Date is currently and correctly recorded, please complete the information in the space provided below. Be sure to sign this form and return it along with any other requested documents.

Name of Provider: _____

Address: _____

_____

_____

_____

_____
Fiscal Year Ending Date

_____
Signature

HSS-ALL-21 (revised 07/24/09; 8/11; 02/12)

Health Standards Section
• P.O. Box 3767 • Baton Rouge, Louisiana 70821-3767
Phone #: 225/342-0138 • Fax #: 225/342-5073 •http://new.dhh.louisiana.gov/

CRIMINAL HISTORY CHECKS

Nursing Homes, Intermediate Care Facilities for Developmentally Disabled, Home Health Agencies, Hospices, and Ambulance services (Emergency Medical Transportation)

In accordance with Louisiana Revised Statute 40:1300.51 through 40:1300.56, prior to any employer making an offer to employ or to contract with a non-licensed person or any licensed ambulance personnel to provide nursing care, health-related services, medic services or supportive assistance to any individual, the employer shall request a criminal history check be conducted on the non-licensed person or any licensed ambulance personnel. The office of State Police or authorized agency, as defined in LA R.S.40:1300.51, will perform criminal history checks on non-licensed personnel of health care facilities and licensed ambulance personnel. The employer shall provide the office or authorized agency any relevant information and fee required to conduct the criminal history check. It is the responsibility of your facility/agency to contact the office of State Police to obtain the required forms and fee information.

For further information regarding criminal history checks, please contact the Office of State Police – Criminal Records Applicant Section at (225)925-1886.

(revised 05/07/2010; 01/2012; 02/2012)

DEPARTMENT OF HEALTH
AND HOSPITALS

Health Standards Section

KEY PERSONNEL CHANGE FORM

Please do not submit personnel's SSN or professional license number

Agency Name:	**Provider License #:**
Address: **City, State, Zip:**	**Provider CMS ID if applies#:**
Telephone Number: **Fax :**	**Email Address:**

Circle the Position that is changing: Director of Nurses Alternate Director of Nurses Administrator Alternate Administrator Director Other:_____

Previous employee in this position: _____

Proposed employee for this position: _____

Date of the proposed change: ____/____/____

EDUCATIONAL QUALIFICATIONS OF EMPLOYEE

COLLEGE/SCHOOL	GRADUATION DATES	DEGREE OBTAINED

Current LA Licensure Verification Date: ____/____/____

EMPLOYMENT HISTORY

This section may not apply to all providers; Please refer to the licensing standards for your program and submit information as required. *DON of Psych Hospital - a copy of the employee resume and CEUs are required with this form.

Start Date	End Date	Facility Name Address	List of job duties performed & Number of personnel supervised

Signature/Title of person verifying the above information: _____

DO NOT WRITE BELOW THIS LINE (FOR STATE OFFICE USE ONLY)

Position: _____ **Approved ( ) Disapproved ( )**

Remarks: _____

_____

Signature/Title: _____ **Date:** ____/____/____

Health Standards Section
P.O. Box 3767 • Baton Rouge, Louisiana 70821-3767
Phone #: 225/342-0138 • Fax #: 225/342-5073 • http://new.dhh.louisiana.gov/